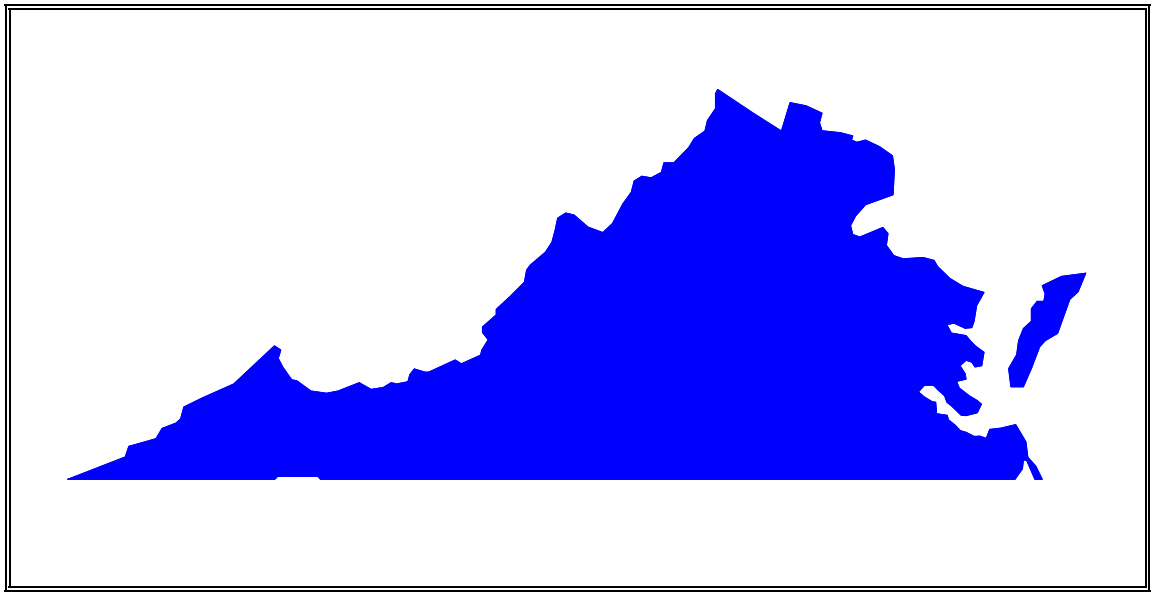
Virginia Department of Medical Assistance Services

Companion Guide

For 834 Benefit Enrollment and Maintenance

Version 1.8 Updated 06/19/2010



ASC X12N 834
VERSION 004010 X095A1

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VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 -	Original Implementation	12/05/2002
Version 1.1 -	Added Page reference 135 Loop 2300 – REF Segment - REF01 data element Added Page reference 135 Loop 2300 – REF Segment - REF02 data element	05/01/2004
Version 1.2 -	Corrected Default value Loop 1000A N102 - Plan Sponsor Name (P3) Corrected Default values Loop 2320 - COB01 - Payer Responsible Sequence Code Corrected Default value Loop 2320 - REF01 - Reference ID Qualifier	06/15/2005
Version 1.3 -	Added Special Notes Modified Comments (Page reference 32-33) Header – REF Segment	12/01/2006
Version 1.4 -	Modified Special Notes	06/06/2007
Version 1.5 -	Added ALTC -Waiver related information Added Additional 2300 Loop to carry waiver information	03/26/2008
Version 1.6 -	Modified the 'Special Notes' section Added Additional 2300 Loop to carry Patient Pay Information	01/26/2009
Version 1.7 -	ACS VAMMIS Fiscal Agent Implementation Change Re-branded documentation for ACS	06/17/2010
Version 1.8 -	Version History Updated	06/19/2010

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N implementation guides. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used for

processing data. This companion document supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

PURPOSE

This guide is concerned with the processing of batch requests and responses submitted to Affiliated Computer Services, Inc. (ACS) as the Fiscal Agent and information source for Virginia Medicaid. ACS adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments.

The 834 transaction is used to provide enrollee rosters to MCOs. Two files are generated by the Managed Care subsystem of VaMMIS per month for each MCO. One file is created on the 20th of the month and the second file is produced on the last day of the month. The month end file contains the prospective capitation payment per enrollee, and the remittance date that payment to the provider will occur in the next month.

One 834 transaction is created for all enrollees in the Medallion II program, including Medicaid and FAMIS. Any enrollee with at least one day of HMO enrollment in the current or subsequent month is included.

SPECIAL NOTES

An HMO may request and obtain an NPI. If an NPI is assigned it will be used. HMOs that do not obtain an NPI will be given a new 10-digit DMAS assigned Atypical Provider ID (API). As of April 2007 the 834 is generated using the HMO's API or NPI. The 10 digit API/ NPI has replaced the 9 digit Legacy Medicaid ID.

The 834 was recently modified to report waiver related information. A new 2300 loop is written out and it would carry the waiver benefit plan, waiver begin and end dates. These segments would only be present for Add (type 021) and Audit (type 030) records and sent out only when waiver information is available on database. These segments can be easily ignored by the HMOs if they are not required for processing.

Starting March 1st 2009, the 834 will include a new Loop 2300 for Patient Pay information. The Patient Pay amount will be sent in AMT segment with AMT01= 'C1'. The Patient Pay begin and end dates are sent in the DTP segment with qualifiers '348' and '349' in DTP01. These segments can be easily ignored by the HMO if they are not required for processing.

ACS uses the MOVEit® DMZ application to transmit batch EDI data into the Virginia Medicaid system. All Service Centers must have applied and been authorized by the Virginia EDI Coordinators office before using MOVEit® DMZ.

- **How to use MOVEit® DMZ Application tool for secure file Drop off and Pick up**

  MOVEit® DMZ is a secure file transfer and secure message server. It is a vital component of the MOVEit® family of secure file processing, storage, and transfer products developed by Ipswitch, Inc. Additional help on using MOVEit® DMZ can be located at web page: https://grabit.acs-shc.com/doc/en/help.htm

  These products provide comprehensive, integrated, standards-based solutions for secure handling of sensitive information, including financial files, medical records, legal documents, and personal data.

  Providers or Service Centers can elect to pick up or drop off your EDI files (batches) for the batch staging queue. This requires a User Id and Password be allocated by the EDI Coordinators office. You can use either of the following methods to access MOVEit® DMZ:

  a. A Web browser can be used to obtain access to the MOVEit® DMZ repository at web site http://grabit.acs-shc.com.

  b. Using an SFTP Client application referencing the URL grabit.acs-shc.com.

     Note: If you have trouble connecting with the URL grabit.acs-shc.com, you should talk with your technical staff about using the DOS command "nslookup" to get the grabit.acs-shc.com IP Address and drop this value into your URL to connect to MOVEit® DMZ.

     Next you will have to make sure and use the correct port depending on the protocol your company uses. The following table will help identify the port required based on the protocol being used by your company.

IF	THEN
SFTP over SSH	use port 22
SFTP over TLS-P*	use ports 21 and 20
SFTP over TLS-Implicit*	use port 990
SFTP over SSL	use port 443

**NOTE: Both TLS options will use ports 3000 to 3008, but their firewalls should automatically allow this if the initial connections are made to the ports specified above.*

DATA ELEMENT DESCRIPTION

Page	Loop	Segment	Data Element	Comments
183		ISA	ISA01 - Authorization Information Qualifier	00 – No authorization information present
184		ISA	ISA03 - Security Information Qualifier	00 – No security information present
184		ISA	ISA05 - Interchange ID Qualifier	ZZ – mutually defined
184		ISA	ISA06 - Interchange Sender ID	VMAP FHSC FA
184		ISA	ISA07 - Interchange ID Qualifier	ZZ – Mutually defined
185		ISA	ISA08 - Interchange Receiver ID	Medicaid Service Center
185		ISA	ISA12 - Interchange Control Version Number	00401 - Version Number
186		ISA	ISA14 - Acknowledgment Requested	0 = No acknowledgment requested
186		ISA	ISA15 - Usage Indicator	P = Production or T = Test
186		ISA	ISA16 - Component Element Separator	'>'
188		GS	GS02 - Application Sender's Code	Use 'VMAP FHSC FA'
188		GS	GS03 - Application Receiver's Code	4 digit Service Center ID assigned by Virginia Medicaid
189		GS	GS08 - Version/Release/Industry Identifier Code	004010X095A1
32		REF	REF01- Ref ID Qualifier	38-Master Policy Number
33		REF	REF02- Reference ID	HMO Provider NPI or DMAS assigned API
36	1000A	N1	N102 - Plan Sponsor Name (P3)	Department of Medical Assistance Services
36	1000A	N1	N104 - ID Code	DMAS Federal Tax ID 546116277
38	1000B	N1	N102 - Insurer Name (IN)	Provider name
38	1000B	N1	N104 - ID Code	Provider federal tax id
Page	**Loop**	**Segment**	**Data Element**	**Comments**
51	2000	REF	REF01 - Ref ID Qualifier	0F – Subscriber number
52	2000	REF	REF02 - Reference ID	Recipient number
55	2000	REF	REF01 - Ref ID Qualifier	17 – Client reporting category
55	2000	REF	REF02 - Reference ID	Program designation code
129	2300	HD	HD03 - Insurance Line Code	HMO - Health Maintenance Organization
130	2300	HD	HD04 - Plan Coverage Description	Benefit plan package code
134	2300	AMT	AMT01 - Amount Qualifier Code	P3 – Premium amount
134	2300	AMT	AMT02 - Monetary Amount	Capitation amount - Payments only appear with the end of the month processing.

135	2300	REF	REF01 – Ref ID Qualifier	17 – Client reporting category
135	2300	REF	REF02 – Reference ID	AID Category
The following loop can occur 5 times and provides information to a Third Party Administrator				
150	2320	COB	COB01 - Payer Responsible Sequence Code	'P' for PRIMARY ,'S' for Secondary
151	2320	COB	COB02 - Reference ID	TPL policy number
151	2320	COB	COB03 - COB Code	1 – Coordination of benefits
152	2320	REF	REF01 - Reference ID Qualifier	60 - Account Suffix Code
152	2320	REF	REF02 - Reference ID	TPL coverage type
154	2320	N1	N101 - Entity ID Code	IN – Insurer
154	2320	N1	N102 - Name	TPL carrier name
156	2320	DTP	DTP01 - Date/Time Qualifier	344 - COB Begin Date
157	2320	DTP	DTP03 - Date Time Period	TPL Begin Date
156	2320	DTP	DTP01 - Date/Time Qualifier	345 - COB End Date
157	2320	DTP	DTP03 - Date Time Period	TPL End Date
This additional 2300 loop will carry waiver segments (Present only for Add and Audit Records)				
129	2300	HD	HD01-Maintenance type code	021 for Adds 030 for Audits
129	2300	HD	HD03 - Insurance Line Code	HMO - Health Maintenance Organization
130	2300	HD	HD04 - Plan Coverage Description	Benefit plan package code
132	2300	DTP	DTP01 - Date/Time Qualifier	348 for Waiver begin date
133	2300	DTP	DTP03 - Date Time Period	Waiver begin date
132	2300	DTP	DTP01 - Date/Time Qualifier	349 for Waiver end date
133	2300	DTP	DTP03 - Date Time Period	Waiver end date
135	2300	REF	REF01 - Reference ID Qualifier	1L for Group or Policy Number
136	2300	REF	REF02 - Reference ID	First two characters of Benefit Plan (Default to 00 when not present)
This additional 2300 loop will carry Patient Pay Information (Present only for Add and Audit Records)				
129	2300	HD	HD01-Maintenance type code	021 for Adds 030 for Audits
129	2300	HD	HD03 - Insurance Line Code	HMO - Health Maintenance Organization
132	2300	DTP	DTP01 - Date/Time Qualifier	348 for Patient Pay begin date
133	2300	DTP	DTP03 - Date Time Period	Patient Pay begin date
132	2300	DTP	DTP01 - Date/Time Qualifier	349 for Patient Pay end date

133	2300	DTP	DTP03 - Date Time Period	Patient Pay end date
136	2300	AMT	AMT01- Amount qualifier Code	C1 for Patient Pay
135	2300	AMT	AMT02- Monetary amount	Patient Pay Amount
135	2300	REF	REF01 - Reference ID Qualifier	1L for Group or Policy Number
136	2300	REF	REF02 - Reference ID	Default to 00